Appendix 1A
National HCFA 1500 Claim Form (Completed)

APPROVED OMB-0938-0008

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY / STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY / STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO — If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. [S1] . — 3. . —

2. . — 4. . —

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 01 96	02 07 12	0	1	W6053		1	XXXX	4				
2 08 01 96		0	1	W6056		1	XXXX	1.5				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ XXXX

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized — MM/DD/YY

SIGNED — DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# — GRP# 76543218

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500